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Original research

"You Have To Be Healthy And Resourceful To Be Seriously Ill" An Open-Ended Question Study Of Patients Experiences Of Care After Deliberate Self-Poisoning

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***Abstract*:** Background: Knowledge of deliberate self-poisoning (DSP) patients experiences of their aftercare is sparse. In order to suggest improvement of health care services and design clinical trials subjective knowledge from service users is important. Objective: To obtain more individual and nuanced knowledge about how DSP patients experience aftercare. Material and methods: Three and six months after discharge from a general hospital, 202 DSP patients received a form with open-ended questions in order to elaborate on their experiences and provide suggestions to improve the post discharge treatment. We used thematic analyses to identify common factors. Results: There were large variations in the patient's satisfactions with the aftercare. Three main themes were identified with common sub factors: 1) *Improvement of treatment facilities;* Waiting time, availability and stability. 2) *Characteristics of- and relations to health care professionals*; A good relation, interest, focus on the patient's problems, trust, accept, being listened to and to be taken seriously. *3) Patient's feelings and needs;* Hopelessness, difficulties with seeking help and lack of own recourses. Conclusions: There were large variations in the patient's experiences of the aftercare. Although some patients were very satisfied, others did not receive any help and was dissatisfied. There is a need to improve the aftercare to DSP patients; especially because of the burden of problems in the post discharge period is severe, the patients are fragile and unable to cope with their situation.

Keywords: *Aftercare, Deliberate self-poisoning, Patients experiences, Suicide attempt*

Deliberate Self-Poisoning (DSP) is one of the strongest predictors for repeated suicide attempt and completed suicide (Bjornaas, Jacobsen, Haldorsen, & Ekeberg, 2009; Heyerdahl et al., 2009; Owens, Horrocks, & House, 2002).
A comprehensive literature review found that one in 25 patients presenting to hospital for self-harm would kill themselves in the next 5 years. (Carroll, Metcalfe, & Gunnell, 2014).

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The period after discharge from hospital is an opportunity to provide adequate help, and for some of the patients the first contact with health care services and the only gateway into further care. However, in many cases aftercare has been insufficient with long waiting time and lack of any appointments in spite of a considerable level of psychosocial problems (Grimholt, Bjornaas, Jacobsen, Dieserud, & Ekeberg, 2012). The most common follow up is from General Practitioner (GP) and psychiatric outpatient clinic while ten per

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cent are admitted to psychiatric inpatient care (Bjornaas et al., 2010). A considerable part don't notify that an appointment was scheduled for them after discharge from the hospital (Grimholt et al., 2012)

In the Norwegian health care system, patients are entitled to and must register with a General Practitioner (GP). Access to a specialist is available only by referral from the GP (Apart from private and often expensive specialists e.g. psychologist). Norwegian GPs are not required to take mental health training as part of their continuing professional development. Norway has in contrast to several countries in the Organization for Economic Co-operation and Development not fully exploited the tool "Individual Care Plan"to improve co-ordination and good quality of care between mental and physical health. The Norwegian Social welfare system and health care cover social security and sickness benefits. Every Norwegian citizen is entitled to essential medical and care services and admission to hospital is free of charge. However a fee must be paid for using many services. If the fees are substantial, Norwegian citizens are entitled to an exemption card and will not have to pay most fees (http://www.oecd.org/els/health-systems/Caring-for-Quality-in-Health-Final-report.pdf). The rationale for this study was that although we, to a certain extent, have knowledge about the DSP patient's experiences from the treatment at the hospital (Taylor, Hawton, Fortune, & Kapur, 2009), knowledge about how DSP patient's experience health care services post discharge is sparse. In order to inform care planning and thus provide increased help to individuals that deliberately self-poison more in depth-knowledge is important. Such knowledge is also important to design clinical trials, because as described sufficient evidence to guide intervention research is lacking (Kapur, Cooper, Bennewith, Gunnell, & Hawton, 2010). To determine which specific factors that might make follow-up contact modalities or methods more effective than others more research is needed (Luxton, June, & Comtois, 2013). Qualitative research in this area is sparse and almost exclusively based on quantitative predefined questions (Hjelmeland & Knizek, 2010). In the current study we aimed to obtain a more nuanced picture of how DSP patient's viewed their aftercare by adding open-ended questions.

Method

We conducted a study with open-ended questions (Table 1). The data were collected as a part of a multicentre randomized controlled trial conducted at five hospitals in Oslo and the neighbor Akershus County. The total period of inclusion was from November 2009 to December 2013. The area has a population of about one million inhabitants. The quantitative results have been reported separately (Grimholt et al., 2015a, 2015b). Patients hospitalized for deliberate self-poisoning (n=202) received a questionnaire three and six months after discharge. By choosing this approach, the patients were provided with an opportunity to elaborate on important aspects of their aftercare that might not been captured in the closed questions.

We registered demographic data at baseline in the hospital and diagnoses from the medical charts in line with the International Classification of diseases (ICD-10).

The responses were categorized into positive, neutral and negative. In order to investigate whether there were differences between the patients that filled out the open ended responses and the ones that did not, we used a chi- square test in SPSS. Chic. Ill. Vs. 23. P- values < 0.05 were considered statistically significant.

Table 1 The open-ended questions

✓	**If you look back upon the follow up/treatment you received/did not receive, did you wish that something had been different?**
✓	**What kind of help did you need?**
✓	**Who do you think could have provided that help for you?**
✓	**Are there other issues with your follow up treatment that is important and that you want to elaborate on?**
✓	**There might be issues with your healthcare that is important to you, but not asked about in this questionnaire, if you want you can write about it here.**

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Results

Of the total sample (n=202), the response rates were 53 % at three months and 50 % after six months. Of these, 70 % were returned with answers on one or more of the open-ended questions at both times. There were no significant differences in gender or diagnoses between those who filled out the open ended questions and the total sample.

In the sample, the mean age was 39.6 years (SD 14.3). There were 72 % females. Fifty percent had previously received- or received present treatment. The self reported intentions varied from a cry for help to a wish to die.

Among the patients that were registered with diagnoses, there were 26 % with F 30-39 Affective disorders, 16 % F 60-69 Personality disorders, 17 % F 40-43 Adjustment disorders and 10 % F 10-19 Substance abuse disorders. There were no significant differences with regard to age, gender or diagnoses and whether the responses were negative, neutral or positive.

Three months after discharge, there were 14 % of the responses that were positive, 34 % neutral and 52 % negative. After six months, the figures were 10 %, 50 % and 40 % respectively. Table 2 illustrates responses at three months to the questions about whether follow-up could have been different, what kind of help the patients needed and their suggestions about whom that could have provided help.

Table 2 Responses to the questions about whether something could have been different, need for help and suggestions categorized into positive, neutral and negative responses

POSITIVE RESPONSES		
If you look back upon the follow up/treatment you received/did not receive, did you wish that something had been different?	*What kind of help did you need?*	*Who do you think could have provided that help for you?*
No		
Everything has been good		
It has been Ok		
Not that I can think of		
No, have received very good help		
I am satisfied with the treatment I have received		
No I am satisfied with the treatment I have received. I don't need any more treatment		
No I don't think that any of this could have been done differently. Very satisfied with the follow up		
I think that I gained from the Acute team because it was possible to call them at night		
Follow up and treatment has been very available, frequent appointments with the GP and psychologist, and possibility to call doctor or acute team if necessary		I have not started with treatment yet. This could have happened much earlier. GP and psychologist could have talked together, instead they have disagreed in each others evaluations and has made me concerned with regard to a diagnose
NEUTRAL RESPONSES		
If you look back upon the follow up/treatment you received/did not receive, did you wish that something had been different?	*What kind of help did you need?*	*Who do you think could have provided that help for you?*
Aftercare	Cognitive and mindfulness	
I haven't had any follow up		
Graduate school and with my economy	Get well	I don't know

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Life coach	Guidance with regard to work and education	
Move on with my life		First and foremost myself
Economic help	Economy	
New liver, addict free		Nobody, China or India
Proper help	My psychological condition	The people that are experts on this area (depression, traumas etc.)
Closer follow up from DPC	Handle my personality disorder	My psychologist
I need medication, therapy or hospitalization	I am f** depressed and exhausted	Psychologist/ Psychiatric clinic
Closer follow up. Several times per week		
A question about why I did something so dramatically		I don't know
I don't need any more follow up other than what I received, however I am surprised about how little follow up I actually received		
	I need to help myself, which I cannot do	
It is important that I have a psychologist to talk to and help me see a future		
My wife should have got more help and information about psychiatric care together with me.		
I did not want any help for MYSELF, but did it for the sake of my family. To calm them		
Help to me and my son	Son with drug problems	I don't know
I have only been there twice. I don't want to mess it all up again. I am not ready yet	Get things in order. Get my life in order	
The help I receive now, I wish that I received it earlier		
Get help to get into Modum bad (Psychiatric institution)	Be able to be outside among other people	Conversational therapy
Treatment during hospital stay.	Real trauma treatment.	Obviously nobody.
I haven't received any help	Conversation	Someone in the health care system
I have said that I didn't want any help, but wanted them to be more aggressive	A telephone call to feel that something helps, because I say everything is OK until it says BOOM!!	Psychiatric health care
NEGATIVE RESPONSES		
If you look back upon the follow up/treatment you received/did not receive, did you wish that something had been different?	*What kind of help did you need?*	*Who do you think could have provided that help for you?*
Everything	Conversations, hospitalization	Everything from "the Lord" to the "man in the street"
To have a better offer during summer vacation		

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To take my daughter seriously and not let me mislead them	Conversations with professional, home visit including family and spouse	
I wanted treatment at the DPC but it was denied, something I find highly dangerous as the struggles with my disease are severe		The doctor applied once more, but did not succeed. Still hoping for help, but where can I receive that!!!
A stable continued contact point at the DPC to talk to during assessments. Has been very unstable and had to attach to and dismiss many relations which has made it difficult to find something to hold on to.		
More understanding of my situation and my needs, and that measures were taken which I think had no effect	Sort out feelings, thoughts and practical advice in difficult situations and relations	A psychologist/ psychiatric nurse
GP is the problem. Little knowledge and medication as only help		
The doctor is completely uninterested in my situation		
I wanted more direct therapy. It doesn't help to talk around the problem.	Wish that psychologist/ professional dared to ask me critical questions and challenged me more.	Psychologist or psychiatrist instead of Social worker at the DPC.
I thought it was inappropriate of the psychiatrist at the hospital to say: "Why didn't you go out in the woods to do this?". I received good aftercare.	I struggled for a long time with two ulcers. To contact the my psychiatrist at the DPC	
That someone handled things for me. It is a fulltime job to be "sick", must nag a lot on the system.	Things are not working at all within the welfare system (NAV)	No overview myself, so I find it hard.
I have an appointment. It takes too long time.	Handle anxiety in work.	?
I have received help, however I don't feel any better	To quit having suicidal thoughts	Have no idea
I tried to be hospitalized however it did not work out, went to se the acute out patient clinic four times	Substance abuse	Don't know, psychiatry, institutionalization
Last time I tried to drink myself to death last week I arrived the acute and emergency department with blood alcohol level on x.x (very high). Home next day started to drink more. Tried to be hospitalized by the acute out patient clinic but not. Returned home.		
The psychologist could have been	Sort out the thoughts	The psychologist

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more direct. In addition the psychologist has cancelled a couple of times, and it has taken long time before I hear from him again.		
I wish that they shared the same view about what that would be best for me. Not only focus on diagnoses and theoretical books.	That someone with knowledge and experience could have helped me to gain from my personal relations. With meaninglessness, emptiness and hopelessness	A psychologist/ psychiatrist could maybe have helped me. It had to be some kind of treatment with a good relation.
Change psychiatrist, but since it is so long waiting time I still have the same psychiatrist		
To continuant seeing the psychologist that followed me and to focus on the reason why I ended up in the hospital		
I wish I that I had someone to talk to the time between the suicide attempt and until I got treatment in the institution I applied for on my own		
Better follow up in the primary health care services		
That professionals understand you better		
Wish I could received an appointment wit a psychiatrist after referral		
To receive a psychologist sooner at the DPC		
More trained people on the phone at the Acute team		
That I could have had one and not many different people to relate to over time		
Longer treatment period. More respect.		Actually I have resigned and see that health care will not help.
Faster reaction from the public		
That the training course lasted longer. (KID). Had an appointment with the psychiatrist instead of being dismissed.		
I really wanted to start therapy as soon as possible, but they sent me to clinic for drug abusers		
When I say that I have problems and so on, I have not been taken seriously. It has been 6 months on assessments, but no follow up	Sleeping problems, talking	General Practitioner, Psychologist
The psychologist did not take me seriously. Didn't want to discuss the things I felt was important.	Quit self-injury, become better of eating disorders	A psychologist that did not dismiss me with "you are not acute"

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Wish that I received the help I have got now earlier	To work with emotions/ mood swings	Psychologist, Psychiatric nurse
To continuant seeing the psychologist I had after the last discharge period	Continuant the trauma/ conversational therapy	The psychologist at DPC
It would have been preferable that the psychiatrist did not sleep during sessions	Sort out thoughts and feelings and handle them the right way	A therapist that was awake
Follow up in spite of that the psychiatrist quit DPC, that someone addressed it	A ”diagnose” to receive help	Interdisciplinary, DPC for six months
There is no follow up on me because I don’t have a Norwegian citizenship	Someone could have called and asked if I needed further help	DPC, General Practitioner (It is a problem with GP without a Norwegian personal security number)
Not only advice about what’s smart, but help	Psychological problems, medical treatment	DPC
I haven’t received any help apart from the doctor and medicines.	Wanted help from DPC. To give a diagnose to which disease I have	DPC
”Follow up from private psychologist has been very good, but I am fortunate that can pay for it. It is madness that it is impossible to receive psychiatric treatment with a psychologist or (apart from at the DPC or similar). I couldn’t wait several months to get treatment. I so I have not existed today! I am privileged, I have economy to pay for my treatment”		What kinds of offers are there? Bad information
The GP referred me to DPC. It was dismissed and recommended to seek help with a private psychologist or psychiatrist. I have done that but are now in line and get not help. My experience is that it is hopeless that it is not possible to receive help when you need it.		
Closer follow up preferably by telephone because they know that I am struggling. It is one time, then.. Goodbye	Some codes to get me out of depression and anxiety.	I have no idea. Someone with relevant education and life experience.

Three main themes emerged from the data:

a) Improvement of treatment facilities.
b) Characteristics and relations to health care personnel.
c) The patient’s feelings and needs.

Improvement of treatment facilities

The most common highlighted obstacles were the long waiting time. One patient wrote that when he finally received an appointment, “it was too late”. Other issues related to the health care services were a need for continuity and availability, more frequent appointments and someone stable to talk to in between therapy sessions.

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Stability
"… That I could have had one, and not a lot of different treatment persons to relate to"
The need to coordinate and be referred to varied care services like GP, Psychiatric out patient clinic and social welfare services was underlined. It was also a problem that the different services did not cooperate because there was a disagreement between the professional's view of the patients' diagnoses and what kind of treatment that was necessary.
Availability was also highlighted as one main area for improvement. The need to receive treatment not exclusively from public health care services was underlined, because of the long waiting time that sometimes was several weeks. However, other patients underlined that treatment in private health care, where the waiting time was shorter was too expensive. Further, access to help during holidays and weekends was highlighted.
Low threshold and an opportunity to call at any time were listed as important and helpful. Many patients also found the treatment insufficient and the period too short.
This patient describe his satisfaction with the psychiatric public acute team:
"…Especially that they are available almost all the time and that it is low threshold. Even though there are many people there and hard for me to ask for help, they are an alternative when the pain is so high that the suicide feels like the only way out"

Help seeking
As the latter quote also describe, patients thought that it was difficult to ask for- and seek help and coordinate everything alone.
This patient described how he had to monitor his own treatment:
" Feel like each and everyone that has participated in cooperation meetings, I have to nag, remind them of things, long waiting time or no answer to inquiries… Very bad follow up from NAV[1] in the community. Hopeless!!!!"
Especially the problems with social well fair services were reported as a main challenge:
" It is hard and frightening to cooperate with NAV… It destroys a lot of the little hope I have seen the last months"
or:
"The biggest problem is NAV. They try the best they can to stab you with a knife".
One patient wrote an illustrating answer: *"You have to be really healthy and resourceful to be seriously ill".*

This statement was supported by responses from patients who described their struggling with daily life activities, like buying their own food, paying bills and so on.
Some even hadn't enough energy to write down their own needs in the questionnaire:
" I have ME (Chronic fatigue), and don't have energy to write anything more here.."
Two other patients' responses support this:
"Have a need for help to help myself. Which I cannot do"
And:
" I am in need of psychiatric help immediately because I cannot help myself and it is tough for the family. It is sad that there is not an offer for everyone to go to DPC. I know a lot of people that doesn't receive any help, me included"
The latter patient also underlines one important factor, namely the need for a holistic approach that several patients describe: To include family and next of a kin. One patient describe that he does not know how to talk to his family after the suicide attempt:
"They never say anything, and the silence and covering of the incident is unbearable".

Contrary to these findings, some of the responses indicated satisfaction with the received aftercare:
"Everything has been good".
Some patients did not receive any aftercare, and found it surprising:
"Even though I am fine and don't need anything at this point, I am surprised that I was not offered any aftercare"

Characteristics and relations to health care professionals
Good relations, interest, focus on the patient's problems, trust, accept, to listen to- and take the patients seriously was common factors.
Some patients described that meeting an understanding person was important for their recovery.
" I am grateful *to be able to see a skilled psychologist*", although *it was not always important whether it was a health care professional*
and:
"It doesn't matter whether it is a psychiatrist or a psychologist or a nurse as long as it is someone who cares".

Others described that untraditional therapy forms (e.g. still point and The Rosen method) were more helpful than anything else, even though they had been in the medical system for years. But they were not sure whether it was the actual therapy

[1] Norwegian social and welfare services

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form or the relation with the therapist that was helpful.
Many patients described a need to have hope for the future. A good relationship with a health care professional, or to know that they would receive help and treatment in the future provided hope among the patients.
However, when planned treatment was terminated or for other reasons denied, it was a new defeat and the patients felt disappointed and lost hope.
One patient listed several follow up measures that he was promised at the time of discharge, however, he did not receive any of them and wrote:
"….What happened? It is obvious that people at the DPC (District psychiatric outpatient clinic) are fun-liars. Is not strange that people commit suicide, is it?
The patients also described a need to feel accepted, and their problems to be taken seriously. One patient wrote:
"I do no longer think that the most important is to se a psychiatrist, psychologist, general practitioner, psychiatric nurse or others. The most important is how you are met and the relationship with that person will be. When the General Practitioner never even has asked about the suicide attempt, it doesn't matter whether it is a doctor or not. Better to talk to a non- professional person who cares rather than a psychiatrist who only cares for diagnoses and methods."
Two other patients wrote:
"The doctor is completely uninterested in my situation"
And:
"*I am afraid of doctors*"

The patient's feelings and needs
There were large differences in the patients' post discharge problems and needs.
While some patients wanted to leave the incident behind, not rip up the past and forget the incident, others needed more intensive treatment and some even wanted to be hospitalized.

Somatic illness and comorbidity
Several patients described their somatic diseases; some of them had serious prognoses:
"*I wish that the lung cancer had been discovered earlier*"
" *I have liver cirrhosis because of alcohol use, and for me there is no hope anymore*"
Further, comorbidity was common;
"*.. A lot of problems (psychological, jumping pulse, peptic ulcer, osteoporosis, sleeping problems… after surgery I have scary problems. Numbness, loss of sensitivity in legs, spasms in legs… "*
Comorbidity with drug addiction made patients feel that they did not fit into the system. One patient wrote that the GP and psychologist only argued back and forth whether they had a certain diagnosis or not.
Together with the hopelessness that many patients described, this quote from one patient represents many of the feelings the patients described:
"*My general practitioner has quit, so I got another general practitioner. I have to go to prison for seven months. These days I am very restless, unsure, afraid and helpless."*

Discussion

There were large variations in the patient's experiences of aftercare. Some were very satisfied with the health care services and contrary descriptions of poor follow up and several obstacles were demonstrated.
Due to the relation with health care professionals, this also differed from patients that had experienced a very helpful and stable contact up to the other end of the scale where professionals were described as totally uninterested. The patient's personal needs varied. Many lacked recourses to seek help and this was often due to socioeconomic problems, serious somatic illness, comorbidity and severe psychiatric symptoms.

Clinical implications and interpretations
In the current study we found that some of the patients wanted to leave their problems and the poisoning episode behind. One possible explanation of this finding could be knowledge from research that describe that some patients fear that by discussing their problems, it would intensify their distress by bringing back repressed memories (Taylor et al., 2009).
Findings that the patients wanted to be treated with respect are also described in a previous study of patients' experiences post discharge (Rotheram-Borus et al., 1999).
Knowledge from previous qualitative studies have underlined that patients want to be listened to, not judged, and get responses naturally with concern and support (Brophy, 2009).
The findings in our study support these factors. One patient did not care whether he talked to a professional as long as it was someone that really cared. This is also underpinned by findings from a qualitative in depth interview study where participants explained helpful existing relationships with professionals such as in the example with this general practitioner: "He [general practitioner] was

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like rock. He really was, he was genuinely concerned for me and I could tell he was. He was really worried and in a way he made me feel better you know that someone cared and he, you know, he would see me every, maybe every month every two months just to see how everything was and till he retired really so he was a great help" (Sinclair & Green, 2005). This quote also highlights the finding in our study of the need for someone stable to talk to between therapy sessions. In a randomized controlled clinical trial where deliberate self poisoning patients received regular consultations with their GP addressing their psychosocial problems during the first six months after discharge, the intervention group was significantly more satisfied with the fact that their GP listened to their problems and involved them in medical decisions compared with the group who got treatment as usual (Grimholt et al., 2015b). This suggests that the GP could be such a stable contact, but not in all cases as some of the patients in the current study stated that they were afraid of doctors, that their GP never had asked them anything, cancelled appointments and that they only received a prescription for potentially addictive drugs. In clinical practice the discharging physician in the hospital should therefore ensure that the patient's relation with the GP is satisfactory, and also have in mind that not all patients want to share their psychosocial problems before referring them to their GP. It is also important to assess whether the patient has present appointments, is in an on-going treatment programme etc. and whether this is functioning.

Loss of hope

The disappointment when the patients were denied treatment or in other ways dismissed from planned appointments, was described as an event that led to loss of hope. This should be stressed in follow up, as we know that many patients are vulnerable and avoidant of help seeking. Further, this underpins the importance of coordinating health care services to avoid yet another rejection. This is especially important because of the well known high levels of hopelessness and eventually suicide are strongly correlated (Beck, Brown, Berchick, Stewart, & Steer, 1990).

Taken together, the diverging results highlight a need for individually oriented care, and that no recommendations of follow up by one specific health care service can be made. Thorough assessment of the patients' problems in broad context together with their own preferences is essential before making a discharge plan. When a patient is admitted to hospital because of self-poisoning, the acute medical treatment is customized with regard to the toxic agents and clinical parameters. In the same way, the planning of aftercare should include the patient's needs and preferences. There are several reasons for an overdose, for some patients it is an acute crisis and a short follow up period could be sufficient. Others have significant chronic problems or serious psychiatric diagnoses and will only function marginally outside institutionalized care. For the latter group it could also be especially difficult to cope with weekends and holidays by themselves. One example is if a patient has a difficult relationship to a health care professional or the GP, other pathways should be discovered with the patient before discharge.

Another example is when a patient have negative experiences from psychiatric inpatient treatment, other options e.g. a prolonged stay in the medical ward should be discussed. This will also include the important user perspective in health care services.

In the current study, some of the patients described a lack of self-management to obtain professional help. Wu and colleagues demonstrated that help-seeking experiences was related to the physician-patient relationship, social support and treatment adherence and further that this was facilitated by supportive attitudes and continuous care from formal and informal sources (Wu, Whitley, Stewart, & Liu, 2012). To prevent further self harm, it is therefore important to ensure that the patients have a plan for help seeking when an eventual new suicidal crisis emerges. As shown by Wu et al. friends, family members were also pathways into medical care. This underline that the patients primary resources should be identified before discharge in order to establish a safety plan. A detailed plan for coping and help seeking have shown promising results (Skovgaard Larsen, Frandsen, & Erlangsen, 2016).

Taylor and colleagues described that service users who terminated treatment early cited difficulties with therapists e.g. feeling uncomfortable with the therapist or that the sessions did not help or that they had got all they could out of therapy (Taylor et al., 2009). This supports the importance of providing a stable contact. Further it might also partly explain the well known problem with low treatment compliance in this patient group (Wittouck et al., 2010). One study demonstrated that compliance with treatment was higher if plans for follow up were made before discharge (Granboulan, Roudot-Thoraval, Lemerle, & Alvin, 2001). In a Norwegian study a considerable part of the patients had not notified the appointment registered at the hospital at the time of discharge (Grimholt et al., 2012). It is therefore important to

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provide sufficiently information to the patients about the plans for post discharge schedule.

Comorbidity and somatic illness

It is well documented that physical health and life expectancy are severely compromised among DSH patients. The standardized mortality ratios in a cohort of DSH patients in the UK were 3.6 and death occurred by natural causes 2-7.5 times more frequently than expected (Bergen et al., 2012). The same study demonstrated that Years lost to life (YLL) for natural causes of deaths was 25.9 years. Prevalence of drug misuse, alcoholism, somatic disease, social disadvantage and life style factors are potential explanations of the high mortality rates in this group (Hawton, Harriss, & Zahl, 2006). The findings of comorbid psychological distress and somatic illness underline the need to appraisal the patient's somatic condition when a patient is treated exclusively in psychiatric care and vice versa. It is therefore important that health care providers are aware of these factors, and ensure that their patient's total health is taken comprehensively care of.

Postvention and further research

The vast majority of randomised controlled clinical trials have been designed in line with standard treatment (follow up interventions) for all patients with the same behaviour (deliberate self harm). Because of the discrepancy between the patient's preferences for their aftercare, unintentional effects might occur. Particularly patients, who do not want help and leave the episode behind, might counteract a possible effect in groups that need intensive care and further diminish when analysed at a group level. In the future more homogenous groups with regard to the patients aftercare preferences should be studied and the ethical committee should be challenged with regard to permit an opportunity to follow drop outs in e.g. National Clinical registries.

Strengths and limitations

The strength of the methodology we used in this study was that it allowed the patients to elaborate on their self-perceived needs, bring up important topics and thus identify new issues contrary to studies that use pre-defined questions and thus cannot capture the nuances. Another strength was that the patients' sense of confidentiality might have been increased in contrast to face-to-face interviews and facilitated a more thorough and personal description of their personal thoughts and feelings. The large number of participants also increases the divergent and contrasting findings, although there was a considerable number that did not return the questionnaire with additional information.

The first limitation was that it was not possible to obtain a verification of the findings from the participant's because we did not have permission from the ethical committee.

Second, in contrast to qualitative in depth interviews it was not possible to ask follow up questions to elaborate on new themes that emerged. Third, the generalization of the results due to the follow up treatment is limited as Norwegian health care services might differ from health care services in other countries. The findings can therefore not provide evidence about the experiences of the population deliberate self-poison as a whole. However the feelings and personal needs reported by the Norwegian patients will to some extent be shared regardless of nationality, and support the understanding of the patient's post discharge condition. Especially in the western parts of the world, where organizational structures of health care services to some extent is similar. In a literature review of deliberate self harm patients their experiences were remarkably similar despite the variations in healthcare systems and settings (Taylor et al., 2009).

Lastly, the response rate on the open-ended questions was low and therefore it is not possible to know whether the patients that answered the open ended questions are representative for the population of patients with deliberate self-poisoning as a whole. However the high numbers that did answer provide more detailed knowledge compared with previous research within the field of suicidology which almost exclusively have used quantitative methodology (Hjelmeland & Knizek, 2010). The quantitative research paradigm in medicine has like in our field limited a broad understanding by using predefined categories in questionnaires (Malterud, 2001).

Researchers have pointed out that this bias in scope and methodology to a large extent has taken the suicidological field into a dead-end of repetitious research. They further argue that increased focus on understanding and thus extended use of qualitative methodology is essential to bring the field forward (Hjelmeland & Knizek, 2010).

The researcher´s (first author) influence on the data should be considered when reporting qualitative research. In this study, the perspectives of the first author have been explorative and influenced by knowledge from previously reported quantitative research. The current study gathered data as a part of a randomized controlled clinical trial. In the trial the intervention group received

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structured follow up by a general practitioner, and the analyses might be influenced by the first author´s desire to highlight the needs and the satisfaction with their GP. However, these data have already been published, and therefore reduces this this potential influence. Further, there is no distinguishing between the study groups (intervention vs. treatment as usual), as this was not in line with the aims of this paper. The fourth author that reviewed the material, found the same themes and thus the inter-rater reliability was good.

Conclusions

There were large variations in the way the patients described their experiences of aftercare. Some were highly satisfied with the health care services and contrary a description of poor follow up and several obstacles were demonstrated. One of the main obstacles was the limited access and long waiting time to receive health care services. When planned treatment was denied or dismissed it had serious impact on the patients hope for the future.
Due to the relation with health care professionals, this also differed from patients that experienced a very helpful and stable contact up to the other end of the scale where the professionals were described as totally uninterested.
The patient's personal needs varied. A considerable part was struggling with serious health problems. Many lacked recourses to cope and seek help, and this was often due to socioeconomic problems, serious somatic illness, comorbidity and severe psychiatric symptoms.
Taken together the findings in our study highlight that there is a need to improve current health care services by screening- and including the patient's individual preferences before discharge. In particular because of the paradoxal combination that DSP patients to a large extent lack own resources to seek help, often have high levels of psychosocial problems and morbidity and the fact that suicide risk is extremely elevated in this group of patients.

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